Supreme Court, U.S.
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NO.

In The

Supreme Court of the United States

October Term, 1994

ALLSTATE INSURANCE COMPANY,

Petitioner,

vs.

LUFTHANSA GERMAN AIRLINES,

Respondent.

Petition for a Writ of Certiorari to the Michigan Supreme Court

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED FOR REVIEW

Where a coordination of benefits clause in a private contract of insurance comes into conflict with an opposing coordination of benefits clause contained in an employee benefit plan, does the federal common law under ERISA resolve the impasse by "preempting" (invalidating) the private insurer's clause, such that the ERISA plan's clause is given full force and effect (rendering its coverage secondary to the insurer's); or does the federal common law resolve the impasse by according equal validity to the competing clauses, recognizing them as mutually exclusive, and dictating that primary responsibility for the mutually covered loss is shared equally between the two coverage providers?

PARTIES TO THE PROCEEDING AND RULE 29.1 STATEMENT

ALLSTATE INSURANCE COMPANY brought this action as plaintiff against Defendant, LUFTHANSA GERMAN AIRLINES, Respondent herein. STEPHEN ROESCH was also named as a defendant in the original state court complaint, but solely as an interested party as the individual whose benefits are the subject of this priority of coverage dispute. He did not participate or appear in any stage of this litigation, and was voluntarily dismissed at the trial court level.

Petitioner, ALLSTATE INSURANCE COMPANY, is a subsidiary of SEARS, ROEBUCK & COMPANY, and has no subsidiary companies that are not wholly-owned.

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PETITION FOR A WRIT OF CERTIORARI

Allstate Insurance Company respectfully petitions for a writ of certiorari to review the judgment of the Michigan Supreme Court in this case.

OPINIONS BELOW

The trial court opinion in which judgment was granted in favor of Respondent (App., *infra*, 11a-14a), is unreported. The

opinion of the Michigan Court of Appeals affirming the trial court judgment (6a-10a) and its order denying rehearing (5a) are also unreported. The order of the Michigan Supreme Court denying Petitioner's application for leave to appeal (3a-4a) is reported at 446 Mich. 877 without opinion, and the subsequent order of the Michigan Supreme Court denying Petitioner's motion for reconsideration (1a-2a) is unreported.

STATEMENT OF JURISDICTION

The judgment of the Michigan Court of Appeals was entered on December 27, 1993, and was followed by a motion for rehearing that was denied by order of February 15, 1994. Petitioner's application for discretionary review to the Michigan Supreme Court was considered and denied by order of August 29, 1994. As permitted by the Michigan court rules (M.C.R. 7.302(F) and 7.313(E)), Petitioner filed a motion for reconsideration which was considered and denied by order of October 28, 1994; accordingly, this petition for writ of certiorari is due on January 26, 1995 (Supreme Court Rules 13.1 and 13.4). The jurisdiction of this Court is invoked under 28 U.S.C. § 1257(a).

STATUTORY PROVISIONS INVOLVED

This matter arises under the Employment Retirement Income Security Act of 1974 (ERISA). 29 U.S.C. § 1001, *et seq.* Because no provision in ERISA addresses the specific question presented, this case involves the federal common law under ERISA. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110 (1989); *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 56 (1987). *See, D'Oench, Duhme & Co., Inc., v. Federal Deposit Insurance Corporation*, 315 U.S. 447, 465-475 (1942) (Jackson, J., concurring).

The preemption provision, § 514 of ERISA, 29 U.S.C. § 1144, provides in pertinent part:

§ 1144. Other Laws

(a) *Supersedure; effective date*

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) *Construction and application*

* * *

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or

> investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

STATEMENT OF THE CASE

A. Factual Background

The factual background of this case is uncomplicated and undisputed. Stephan Roesch was involved in an automobile accident and incurred medical expenses that were covered both by no-fault automobile insurance coverage with Petitioner Allstate and the medical coverage provided through the ERISA-qualified employee benefit plan of his father's employer, Respondent Lufthansa. Petitioner paid Roesch's medical expenses and filed this action against Respondent seeking a declaration regarding the priority of coverage and reimbursement consistent with such declaration.

Petitioner provided no-fault automobile insurance coverage in accordance with Michigan law. Pursuant to Mich. Comp. Laws § 500.3109a; Mich. Stat. Ann. § 24.13109(1), Petitioner was required to offer its customers like Mr. Roesch the option of purchasing a policy whose coverage would coordinate with "other health and accident coverage." For a reduced premium, Mr. Roesch elected such a coordinated policy and, thus, his policy contains the following provision:

> Coordination of Benefits
>
> If medical expense benefits are identified as

> excess under coverage VA in the declarations [they are], Allstate shall not be liable to the extent that any elements of loss . . . are paid, payable or required to be provided to or on behalf of the named insured or any relative under the provisions of any valid and collectible
>
> (a) Individual, blanket or group accident disability or hospital insurance [or]
>
> (b) Medical or surgical reimbursement plan[.] . . .

(Allstate insurance policy, p. 6, submitted to trial court with Stipulation of Facts; attached hereto at App., *infra*, 15a-16a). Thus, by the terms of the contract with its insured, Petitioner Allstate was not liable for expenses to the extent that they were payable under any other plan such as the Lufthansa employee medical plan.

At the time of the accident, Roesch was also an eligible participant under the Lufthansa medical plan which, according to a schedule of various benefits for medical, hospital and surgical procedures, provided Roesch and his dependents comprehensive coverage for medical expenses (Lufthansa medical plan, submitted to trial court with Stipulation of Facts, pp. 4-13).

Respondent's plan, under the heading "Medical Expenses/ Services Not Covered", designates that certain charges are not payable under the plan; and refers to charges included in the "Coordination of Benefits" section as among those charges not payable under the plan (*id.*, p. 23; attached hereto at App., *infra*, 17a-19a). The referenced Coordination of Benefits provision, in pertinent part, states as follows:

Coordination of Benefits

The Lufthansa German Airlines Medical Plan has been designed assist you in meeting the costs of medical supplies and services. Since it is not intended that anyone receive greater benefits than actual charges incurred, benefits from this Plan will be coordinated with benefits payable from other plans so that no more than 100% of the allowable expenses incurred during a calendar year will be paid.

. . .

This provision applies to —

. . .

* automobile reparations (No-Fault or Uninsured Motorist) insurance which is required under any law of government, unless the law specifically prohibits coordination of benefits.

(*Id.*, p. 24; App., *infra*, 19a-20a). Thus, "the ERISA Plan purport[ed] to assume only excess or secondary liability for expenses incurred as a result of an automobile accident" (Stipulation of Facts, ¶4).[1]

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1. It was Petitioner's contention that Michigan law (specifically, *Federal Kemper Ins. Assoc. v. Health Ins. Admin., Inc.*, 424 Mich. 537, 383 N.W. 2d 590 (1986); *Auto-Owners Insurance Co. v. Lacks Industries*, 156 Mich. App. 837; 402 N.W. 2d 102 (1986), *lv. den.*, 428 Mich. 902 (1987), interpreting Mich. Comp. Laws § 500.3109a; Mich. Stat. Ann. § 24.13109(1)) did specifically prohibit coordination of benefits with a coordinated no-fault

(Cont'd)

To ensure that Roesch's medical expenses did not remain unpaid, Petitioner paid the full amount of incurred expenses in the approximate amount of $67,000. On the basis that it paid expenses that are properly owed and payable by Respondent's medical plan, Petitioner brought this action for a declaration of coverage priority and reimbursement.

B. Proceedings Below

On August 21, 1990, Petitioner filed this case in the Michigan Circuit Court for Oakland County seeking declaratory relief and reimbursement for the medical expenses it had paid. The case was submitted to the trial court for resolution by motions for summary judgment on stipulated facts and documents. The stipulations set forth the fact and form of the parties' coordination of benefits clauses, and also set forth the existence of Respondent's excess risk or "stop-loss" insurance coverage which, Petitioner contended at the time, mandated that Respondent's plan should be deemed an "insured plan" and thus outside the protections of ERISA preemption. *See*, *FMC Corp. v. Holliday*, 498 U.S. 52, 63 (1990). Because subsequent federal case law foreclosed this contention (*Lincoln Mutual Casualty Co. v. Lectron Products, Inc.*, 970 F.2d 206, 210 (6th Cir. 1992)), Petitioner conceded this issue before the Michigan Court of Appeals (App. *infra*, 8a-9a).

(Cont'd)
automobile insurance policy; and that, accordingly, by the terms of the above-quoted plan provision itself, Respondent's coverage did not purport to be subordinated to Petitioner's coverage in the first instance. The Michigan Court of Appeals, however, ruled that Petitioner waived this contention by joining in a Stipulation of Facts establishing that both the Plan and the no-fault policy contained coordination of benefits provisions that "purport to assume only excess or secondary liability . . . and, therefore, the policy and Plan conflict with one another." (*See*, App., *infra*, 9a).

Petitioner's primary position in the trial court was that ERISA did not preempt state law in this case due to the "stop-loss" insurance issue. Petitioner, however, raised alternative arguments in the event preemption was held to apply (Allstate's Brief in Response to Defendant's Motion for Summary Disposition, 8/9/91, pp. 9-10 — e.g. "[e]ven if this Court were to determine that there is valid ERISA preemption, and that the Lufthansa plan does not, by its own terms, incorporate state law, then this Court must determine what federal law is controlling insofar as resolving the conflicting coordination of benefits clauses issue is concerned", citing *Holliday v. Xerox*, 551 F. Supp. 51, 54-55 (E.D. Mich. 1982), *aff'd*, 732 F.2d 548 (6th Cir. 1984), for the proposition that federal common law provides the controlling rule).

The trial court granted Respondent's motion for summary judgment (App., *infra*, 11a-14a). The court found that Respondent's ERISA plan was self-funded and that, therefore, Michigan insurance laws were preempted[2]. On appeal, Petitioner maintained that a finding that Michigan law is preempted did not solve the coverage priority question; that, even if the *Michigan* solution to the coordination of benefits clash was preempted, analysis and ruling was still required to resolve the problem based upon the federal common law.

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2. In Michigan, no-fault automobile insurers are statutorily required to "offer, at appropriately reduced premium rates, deductibles and exclusions reasonably related to other health and accident coverage on the insured." Mich. Comp. Laws § 500.3109a; Mich. Stat. Ann. § 24.13109(1). In order to effectuate this mandated reduction in premiums, the Michigan Supreme Court held in *Federal Kemper Ins. Assoc. v. Health Ins. Admin., Inc.*, 424 Mich. 537; 383 N.W. 2d 590 (1986), that primary liability falls on the health insurer when a conflict exists between the COB clauses of a no-fault insurance policy and another provider of health and accident coverage. See *Auto Club Ins. Assoc. v. Health & Welfare Plans, Inc.*, 961 F.2d 588, 590 n. 3 (6th Cir. 1992); *Lincoln Mutual Casualty Co. v. Lectron Products, Inc.*, 970 F.2d 206, 208 n. 2 (6th Cir. 1992).

In its Opinion issued December 27, 1993, the Michigan Court of Appeals affirmed the grant of summary disposition in favor of Respondent (App., *infra*, 6a-10a). The court declined to address whether the apparent conflict between the competing COB provisions could be resolved by the plan's incorporation of state law, but held that Petitioner's federal common law argument had been properly raised and preserved for review.

The court held that the Respondent plan's COB clause rendered its coverage secondary to that of the no-fault automobile insurance policy issued by Petitioner, and that Petitioner's coverage was thus primary, despite its own COB clause that would subordinate its coverage to that of the plan. The court expressly relied upon the Michigan Supreme Court's recent decision in *Auto Club Ins. Assoc. v. Frederick & Herrud, Inc.*, 443 Mich. 358; 505 N.W. 2d 820 (1993), *cert. denied*, __ U.S. __; 1400 S. Ct. 1300 (1994). Therein, despite clear, recent statements from the Court of Appeals for the Sixth Circuit that, in identical contexts, ERISA preemption does *not* invalidate a private insurer's COB clause as against a conflicting COB clause in an employee benefit plan (*Auto Club Ins. Assoc. v. Health & Welfare Plans, Inc.*, 961 F.2d 588, 592-593 (6th Cir. 1992); *Lincoln Mutual Casualty Co.*, 970 F.2d at 211), the Michigan Supreme Court held that the ERISA plan's COB clause must prevail, effectively rendering void the opposing COB clause in the private insurance contract. 443 Mich. at 389; 505 N.W. 2d at 834.

The Michigan Supreme Court based its decision on federal common law, and, acknowledging that the issue ultimately must be decided by the federal courts, stated that its present purpose was "to anticipate the ultimate federal position." 443 Mich. at 376 n. 31; 505 N.W. 2d at 828 n. 31. The Court of Appeals for the Sixth Circuit soon adopted the Michigan Supreme Court's approach to this issue in *Auto-Owners Insurance Co. v. Thorn Apple Valley, Inc.*, 31 F.3d 371 (6th Cir. 1994), *pet. for cert.*

pending, (No. 94-1137). The court determined that private insurers and ERISA benefit plans do not litigate on a level "playing field", 31 F.2d at 375. Explicitly rejecting the contrary decision of the Seventh Circuit in *Winstead v. Indiana Insurance Co.*, 855 F.2d 430 (7th Cir. 1988), *cert. denied*, 488 U.S. 1030 (1989), the Sixth Circuit posited that the two coordination of benefits clauses do not compete equally because the COB clause in the plan "is bolstered by the preemptive effect of ERISA." 31 F.3d at 375.

REASONS FOR GRANTING THE WRIT

This case presents an important and recurring question of federal law under ERISA. As coverage providers of all types endeavor to minimize costs and prevent payment of needlessly duplicative benefits, disputes over conflicting coordination of benefits clauses between private insurers and ERISA-qualified plans are increasingly common. Because the ERISA statute itself provides no coordination of benefits rule, an appropriate *and uniform* rule of federal common law is needed. As the Fourth Circuit recently observed, the "federal common law [of ERISA] should be consistent across the circuits. To the extent that inconsistencies arise, Congress and the Supreme Court are capable of harmonizing them." *Singer v. Black & Decker Corp.*, 964 F.2d 1449, 1453 (4th Cir. 1992). The degree of inconsistency among the courts being faced with these disputes now requires Supreme Court review.

The decision of the lower court is also fundamentally flawed. As indicated above (*supra*, p. 9), the Sixth Circuit Court of Appeals in *Auto-Owners* adopted the approach taken by the Michigan Supreme Court in *Frederick & Herrud, Inc.*, which was the basis for the court's decision in this case (App., *infra*, 9a-10a). Both the Sixth Circuit and the Michigan Supreme Court erred in

extending the notion of "ERISA preemption" beyond displacement of state *law* to the point of giving preemptive force to plan provisions themselves such that perfectly valid *clauses* in private insurance *contracts* are "preempted." Furthermore, while these courts purported to be protecting the interests of plan participants and their beneficiaries (31 F.3d at 375), in fact they protect only the plans *themselves* by insulating them from claims where coverage exists. The holding is inimical to the interests of covered participants and beneficiaries.

I.

THE SUPREME COURT SHOULD GRANT REVIEW IN THIS PRIORITY OF COVERAGE DISPUTE BETWEEN A PRIVATE INSURER AND AN ERISA BENEFIT PLAN IN ORDER TO ESTABLISH UNIFORMITY IN FEDERAL ERISA LAW CONCERNING COORDINATION OF BENEFITS.

This case raises the question of how to reconcile priority of coverage disputes where both parties would provide primary coverage of the loss but for their mutually exclusive coordination of benefits clauses. The Court should grant review in this case and overrule the holding of the Sixth Circuit Court of Appeals in *Auto-Owners Insurance Co. v. Thorn Apple Valley, Inc., supra.*

Expressly rejecting the holding of the Seventh Circuit in *Winstead v. Indiana Insurance Co.*, 855 F.2d 430 (7th Cir. 1988), *cert. denied*, 488 U.S. 1030 (1989), and despite its own recent precedent establishing that ERISA preemption does not render a private insurer's COB clause void (*Auto Club*, 961 F.2d at 593; *Lincoln Mutual*, 970 F.2d at 211), the Sixth Circuit held that the coordination of benefits (COB) clause of a qualified ERISA plan is to be given full effect, to the detriment of a private insurer whose coverage is subject to an equally valid coordination of benefits clause.

The *Winstead* court had addressed virtually the same set of facts, except that it was the ERISA plan that initially paid the accident victim's medical costs and then sought reimbursement from the automobile insurer. Both carriers had COB provisions to the effect that any other coverage would be primarily liable for the expenses. The automobile insurer claimed that Michigan's special rule announced in *Federal Kemper Ins. Co. v. Health Ins. Admin.*, 424 Mich. 537; 383 N.W. 2d 590 (1986)[3], should apply to render the Fund's coverage primary. In response, the Fund argued not only that the *Federal Kemper* rule could not be imposed upon an ERISA plan, but that "federal ERISA law preempts the Indiana Insurance *policy*." It argued that, to the extent that the insurer's provisions conflicted with its own of coverage, "the terms and condition of the Fund policy must be enforced." *Winstead*, 855 F.2d at 433 (emphasis added).

The Seventh Circuit rejected the plan's notion of ERISA preemption. While agreeing that application of Michigan's *Federal Kemper* rule was preempted[4], it could not accept the suggestion that a provision in the accident victim's insurance contract was encompassed within the scope of ERISA preemption and thereby automatically rendered unenforceable. Instead, the court accorded equal validity to the parties' competing COB clauses, found them to be mutually repugnant

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3. See n. 2, *supra*.

4. In *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), this Court broadly construed the preemption provisions of ERISA to hold that qualified plans could not be subject to state laws that regulate insurance, effectively overruling *Northern Group Services, Inc., v. Auto-Owners Ins. Co.*, 833 F.2d 85 (6th Cir. 1987), *cert. denied*, 486 U.S. 1017 (1988). See *Auto Club Ins. Assoc. v. Health & Welfare Plans, Inc.*, 961 F.2d at 592-593. In *Winstead*, the Seventh Circuit did not apply the *Northern Group Services* analysis. Thus, although it pre-dated *FMC*, *Winstead* is entirely consistent with and in fact foreshadowed the state of the law post-*FMC*. See *Auto Club*, 961 F.2d at 595 n. 14.

and, guided by rules traditionally applied in contract interpretation for reconciling COB clauses, established the federal common law rule that both carriers would share primary responsibility on a pro rata basis. 855 F.2d at 433-434.

The Supreme Court of Kansas likewise has rejected the argument that the COB clause of an ERISA benefits plan must prevail over the competing COB clause of a private insurer's contract. In *Blue Cross and Blue Shield of Kansas, Inc. v. Riverside Hospital*, 237 Kan. 829; 703 P.2d 1384 (1985), a private insurer paid benefits then sought reimbursement from an employee benefit plan. The court examined the language of the competing COB clauses and, applying traditional methods for discerning the intent of the respective coverage providers[5], held that the private insurer was secondary and the ERISA plan was primary. The defendant had "contend[ed], in essence, that by

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5. Courts generally follow one of two approaches to resolve the conflict that arises when two coordinated coverages clash over a given loss. The so-called "majority rule" requires the court to examine the competing clauses to discern the intent of the respective coverage providers based on whether they utilized "escape", "excess" or "pro rata" coordination language, and attempt to reconcile the apparent intentions. The so-called "minority rule" posits that such analysis ultimately is circular, dependent on which policy is read first. Under that approach, opposing COB clauses are deemed to be mutually repugnant regardless of their specific types, and the loss is equally apportioned between the carriers to the extent of their duplicative coverage. Even under the "majority rule," however, the opposing clauses frequently are found to be irreconcilable with the result that primary responsibility is shared equally between the parties. See *St. Paul Fire & Marine Ins. Co. v. American Home Assur. Co.*, 444 Mich. 560, 565-577; 514 N.W. 2d 113 (1994), and cases cited therein; *Blue Cross and Blue Shield of Kansas, Inc. v. Riverside Hospital*, 703 P.2d at 1388-91; *Starks v. Hospital Service Plan of N. J., Inc.*, 182 N.J. Super. 342; 440 A.2d 1353, 1359 (1981), *aff'd*, 91 N.J. 433; 453 A.2d 159 (1982). There is a "growing tendency" toward rejecting the "circular reasoning" of the majority rule. 16 Couch on Insurance, 2d, § 62:79, p. 550 (Lawyers Co-Op. 1983); *Auto Club*, 961 F.2d at 595 n. 13 (minority view now referred to as a " 'popular approach[]' ").

virtue of its plan being rooted in ERISA, it is placed in an unassailable position when challenged by a plan [private insurer] rooted in state law." 703 P.2d at 1388. The court rejected this notion: "The fact that the Riverside plan is rooted in ERISA is not, we believe, a significant factor in the determination of the issue before us. Therefore, the matter of preemption is not involved herein" (*id.*).

The Kansas Supreme Court believed its holding to be "consistent with the rationale expressed in *Northeast Dept. ILGWU v. Teamsters Local Union No. 229*, 764 F.2d 147 (3rd Cir. 1985)." 703 P.2d at 1390. In *ILGWU*, the Third Circuit addressed a conflict between one plan's escape clause and another plan's excess clause, the types of COB clauses present in the case at bar[6].

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6. Petitioner's COB clause provides for "excess" coverage (App., *infra*, 15a), while Respondent's COB clause provides an "escape" from coverage when there is other applicable coverage (App., *infra*, 17a-19a). See 44 Am Jur 2d, Insurance, § 1789, p. 778 (Lawyers Co-Op. 1982). Under the so-called "majority rule" (see n. 5, *supra*), Respondent's coverage would be primary and Petitioner's coverage only secondary. 44 Am Jur 2d, Insurance, § 1791, p. 779:

> Thus, where one of the policies contains an "excess insurance" clause and the other contains a "no liability" clause — that is, a clause providing that there shall be no liability in case a risk is covered by other valid or collectible insurance — liability has been imposed in a majority of cases on the insurer issuing the policy containing the "no liability" clause. The rationale for this holding is that the policy constituting "excess" insurance only did not provide other collectible coverage so far as the "no liability" clause of the other policy was concerned. However, there is also authority for the view that the conflict between such clauses is irreconcilable and that therefore the insurer should be compelled to prorate the loss between them.

Accord, 16 *Couch on Insurance, 2d*, § 62:77, p. 543.

Determining that the competing clauses could not be harmonized by their respective intents ("each plan provides primary coverage unless the other plan provides primary coverage" — 764 F.2d at 161), the court looked to prevailing rules of state common law (*id.* at 162-163) as an appropriate basis for federal common law under ERISA. Because escape clauses are disfavored and generally not enforced as against excess clauses, which are more compatible with the interests of the insured, the court held: "escape clauses in ERISA covered employee benefit plans are unenforceable as a matter of law." *Id.* at 164. Were this holding applied to the case at bar, Respondent's escape clause would be unenforceable and Petitioner's excess COB clause would render the no-fault coverage secondary.[7]

This manifest *lack* of uniformity among ERISA coordination of benefits cases recently prompted the California Court of Appeals to throw up its hands and apply its own *state* law to an ERISA coverage dispute. In *Inter Valley Health Plan v. Blue Cross/Blue Shield of Connecticut*, 16 Cal. App. 4th 60; 19 Cal. Rptr. 2d 782 (1993), *cert. denied*, __ U.S. __ ; 114 S.Ct. 881 (1994), the court noted that the Ninth Circuit had endorsed the "birthday rule" as an appropriate ERISA coordination rule in *PM Group Life Ins. Co. v. Western Growers Assurance Trust*, 953 F.2d 543 (9th Cir. 1992). The California court, however, refused to follow *PM Group Life*; in part due to a factual distinction (divorced/non-divorced parents), but primarily due to the lack of a uniform rule:

> Reasoning from the broad preemption

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7. The Third Circuit's holding was reached in the context of a dispute between two ERISA plans, but the court nowhere suggested that the holding was limited to such circumstances. *ILGWU*, 764 F.2d at 164. Petitioner has not advocated avoidance of Respondent's COB clause, but rather the Seventh Circuit's *Winstead* rule that accords equal validity to the competing clauses. See *Winstead*, 855 F.2d at 434, discussing *ILGWU*.

> provision in ERISA, the *PM Group Life* court focused primarily on the need to adopt a *uniform* federal rule under ERISA[.] . . .
>
> These considerations are not persuasive here. First, *federal law is not uniform, and is not going to be uniform until the United States Supreme Court finally decides the matter. PM Group Life* does not appear to have been aware of cases from the Sixth and Seventh Circuits which adopted an approach altogether different from the birthday rule. (See *Auto Club Ins. v. Health and Welfare Plans* (6th Cir.1992) 961 F.2d 588, 594-595; *Winstead v. Indiana Ins. Co.*, (7th Cir.1988) 855 F.2d 430, 433-434.

Inter Valley, 19 Cal. Rptr. 2d at 786 (emphasis added).

As the above indicates, the California court viewed the Sixth Circuit as already having endorsed *Winstead*'s equal apportionment of primary liability. In rejecting this common sense approach in favor of one which renders the COB clauses of private insurers inferior to those of ERISA plans, the Sixth Circuit in *Auto-Owners* thus not only threw yet another "rule" into the mix, but tacitly contravened its own previous holdings that "ERISA preemption" does *not* invalidate a private insurer's competing, irreconcilable COB clause. *Auto Club*, 961 F.2d at 592-593; *Lincoln Mutual*, 970 F.2d at 211.

ERISA was intended to provide a single, uniform body of federal law to govern disputes involving qualified employee welfare benefit plans. The conflict now existing among the circuits in their approaches to resolving ERISA coverage priority disputes frustrates this purpose. Further review is warranted.

II.

THE MICHIGAN SUPREME COURT, IN THE DECISION THAT DICTATED THE OUTCOME IN THIS CASE AND WHICH HAS NOW BEEN ADOPTED BY THE SIXTH CIRCUIT COURT OF APPEALS, MISAPPLIED THE PRINCIPLE OF ERISA "PREEMPTION" TO THE TERMS OF A PLAN COB PROVISION, CREATING A RULE OF LAW SPECIFICALLY ADVERSE TO THE INTERESTS OF PLAN PARTICIPANTS AND BENEFICIARIES.

1. This case presents a dispute between two providers of medical expense coverage with valid COB clauses that create a logical impasse: both cannot be secondary. The dispute is controlled by ERISA, but ERISA itself contains no coordination of benefits rule. Contrary to the approach taken by the Sixth Circuit Court of Appeals, the solution to the problem is not found in blurry notions of "the preemptive effect of ERISA" (31 F.3d at 375) but in federal common law fashioned after equitable solutions developed by the states. As Justice Brennan observed in *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S.134, 157-158 n. 18 (1985) (Brennan, J., concurring) (quoting *Wayne Chemical, Inc. v. Columbia Agency Service Corp.*, 426 F. Supp. 316, 325 (N.D. Ind.), *modified on other grounds*, 567 F.2d 692 (7th Cir. 1977):

> Where the courts are required themselves to fashion a federal rule of decision, the source of that law must be federal and uniform. Yet, state law where compatible with national policy may be resorted to and adopted as a federal rule of decision. . . . Here, of course, there is little federal law to which the court may turn for guidance. State regulation of

> insurance, pensions, and other such programs, however, provides a pre-existing source of experience and experiment in an area in which there is, as yet, only federal inexperience.

In *Chemung Canal Trust Company v. Sovran Bank/ Maryland*, 939 F.2d 12 (2d Cir. 1991), the Second Circuit recognized in ERISA a federal common law remedy of indemnity and contribution. The court emphasized that it was not creating a right from whole cloth. Rather, "[w]e are simply following the legislative directive to fashion, where congress has not spoken, a federal common law for ERISA by incorporating what has long been embedded in traditional trust law and equity jurisprudence." *Id.* at 16. Pursuant to the same legislative directive, the rule announced in *Winstead* is indeed "in keeping with generally accepted notions derived from state common law [and is] eminently fair and equitable." 855 F.2d at 434.

Thus it is just and equitable that the coverage provider who steps forward and protects the interest of the covered individual should receive reimbursement from the co-primary coverage provider in accordance with and to the extent of the other's liability on an equal share basis. In rejecting the "fair and equitable" solution espoused by the Seventh Circuit in favor of a rule which relegates private insurance contracts to second class status, the Michigan court and the Sixth Circuit in *Auto-Owners* erred.

Congress did not intend to create a fully insulated legal world around ERISA benefit plans. See, *Mackey v. Lanier Collections Agency & Service, Inc.*, 486 U.S. 825, 833 (1988). Rather, coverage conflicts between plans and other insurers should be resolved in accordance with well recognized principles that govern "the reciprocal rights and duties of several insurers

who have covered the same event." *Pacific Indemnity Co. v. Fireman's Fund Insurance Co.*, 175 Cal. App. 3rd 1191, 1197; 223 Cal. Rptr. 312, 315 (1985). The California court described the coverage relationship as follows:

> "The reciprocal rights and duties of several insurers who have covered the same event do not arise out of contract, for their agreements are not with each other . . . Their respective obligations flow from equitable principles designed to accomplish ultimate justice in the bearing of a specific burden. As these principles do not stem from agreement between the insurers their application is not controlled by the language of their contracts with the respective policy holders." . . .

Quoting *Signal Companies, Inc. v. Harbor Ins. Co.*, 27 Cal. 3d 359, 369; 165 Cal. Rptr. 799; 612 P.2d 889 (1980).

> Thus, Signal once again reaffirms the well recognized principle that the rights and duties of several insurers who have covered the same event but have not contracted with each other with respect to it, are not the same to one another as they are to their respective insureds. They are, instead, governed by and "flow from equitable principles designed to accomplish ultimate justice in the bearing of a specific burden."

175 Cal. App. 3rd at 1197-98; 223 Cal. Rptr. at 315. The *Winstead* court preserved and applied the "equitable principles" cited above, and the Sixth Circuit Court of Appeals acknowledged in *Auto-Owners* that the *Winstead* approach would be "eminently

fair" *if* the "playing field" were level. 31 F.3d at 375. The court refused to accord equal legitimacy to the COB clause in the private insurance contract, however, on the basis that "the TAV clause is bolstered by the preemptive effect of ERISA" (*id.*). This reasoning is flawed.

Congress' intent in enacting the ERISA preemption provisions (29 U.S.C. § 1144) was to ensure that plans and plan sponsors would be subject to a uniform body of benefits law, such that they would not be faced with conflicting or inconsistent State and local regulation of employee benefit plans. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990); *FMC Corp. v. Holliday*, 498 U.S. 52, 60, 64-65 (1990). This legislative purpose is fully met where, as here, a specific state law such as Michigan's *Federal Kemper* rule is held to be inapplicable to resolve a COB contest between a private insurer and an ERISA plan. Such was the holding of the district court in the *Auto-Owners* case (*Auto-Owners Insurance Co. v. Thorn Apple Valley*, 818 F. Supp. 1078 (E.D. Mich. 1993), the Sixth Circuit in *Auto Club*, 961 F.2d at 592-593, and the Seventh Circuit in *Winstead*, 855 F.2d at 433.

There is no sound basis, however, for the Sixth Circuit's proposition that "the preemptive effect of ERISA" was intended to "bolster[]" and accord "preemptive" force to whatever coverage priority language appears in a plan when it comes into logical conflict with a perfectly valid coordination of benefits agreement negotiated between a private insurer and its insured.

As the *Winstead* court explained, ERISA preempts *state law*, but it does not void the provisions of private insurance contracts. The court stated:

> [T]he district court rejected the Fund's broad construction of ERISA preemption, explaining that by its own terms ERISA was

designed only to supersede "any and all *State laws* insofar as they may now or hereafter relate to any employee benefit plan." (Emphasis supplied.) . . . *We agree* with the conclusion of the district court that *the relevant provision of the Indiana Insurance policy is not rendered void merely as the result of Crampton's concurrent ERISA coverage.*

The decision to purchase insurance coverage in addition to ERISA coverage featuring an "other insurance" clause is a decision which undoubtedly affects the Fund's potential liability for benefits payments and is, therefore, a decision that "relates to" an ERISA benefits plan. *Id. Crampton's decision to so proceed, however, was a private contractual matter between her and Indiana Insurance*; it was in no way compelled by state law. As the district court properly concluded, nothing in ERISA suggests that individuals are barred from acting as Crampton did in insuring themselves. In fact, the state's ability to facilitate such private choice has been held by the Supreme Court, albeit implicitly, *not* to be preempted by ERISA. See *Metropolitan Life Insurance Company v. Massachusetts*, 471 U.S. 724, 756-58 [] (1985). . . . The choice to avail oneself of [a reduced premium, excess-only automobile insurance] policy is strictly a personal one, and thus a matter that ERISA did not intend to preempt.

Winstead, 855 F.2d at 433 (emphasis in original in part, supplied in part).

When the question is properly viewed as a pure issue of priority involving a *valid* COB clause in an ERISA plan and involving an equally *valid* COB clause in a private contract of insurance, and with full recognition that special state rules (such as *Federal Kemper*) are preempted, ERISA provides no basis for a holding that one COB clause is *more* valid than the other.

2. The Court of Appeals for the Sixth Circuit based its conclusion that the playing field is not level (31 F.3d at 375) on 29 U.S.C. § 1001(b), which defines the purpose of ERISA as protecting "the interests of participants in employee benefit plans and their beneficiaries." The court translated this defined purpose into an obligation to guard the plans (not the beneficiaries) against claims. It erroneously invoked the talisman of "preemption" and deferred to the COB clause in the plan, holding essentially that the terms of the plan will themselves determine the outcome of any dispute involving other coverage contracts. This mirrored the approach taken by the Michigan Supreme Court. 443 Mich. at 387; 505 N.W. 2d at 833. However, as observed by the court in *Wahl v. Northern Telecom, Inc.*, 726 F. Supp. 235 (E.D. Wisc. 1989), this is contrary to the intent of Congress:

> Finding that a self-insured plan is automatically exempt from state insurance regulations, however, does not dictate, as the defendant Northern claims, that the terms of an employee benefit plan are dispositive of the outcome. By preempting state law without providing any federal statute to replace it, Congress intended either (1) to eliminate all regulation of non-core ERISA matters for self-insured plans or (2) to replace

> the state regulations with federal common law.
>
> * * *
>
> If a court holds that federal common law dictates that the [beneficiary's] rights are determined solely by the employee benefit plan, then it essentially is holding that there is no federal regulation of this area of the law. This outcome, however, does not appear to be what Congress intended. Nowhere in the legislative history of ERISA does it appear that Congress wanted to reduce the substantive rights of participants and beneficiaries by allowing self-insured plans to be unregulated. . . .

Id. at 240-241.

Beneficiaries of an "unregulated" plan do not have their interests protected. Further, under the holding of the Michigan Supreme Court and Sixth Circuit Court of Appeals, ERISA plan members who drive automobiles will be disadvantaged by a plan's unregulated determination that it will not cover medical expenses incurred in an automobile accident when there is other insurance.

Michigan drivers, like those in most states, are required to purchase automobile insurance for their vehicles if they are to be driven on public roads. Individuals have the option of purchasing policies with full, unqualified medical coverage, or for a substantially reduced premium, electing a policy that coordinates with the insured's general health coverage plan, provided their health coverage plan extends to automobile accident-related

expenses. Most Michigan drivers that have other health coverage elect the less expensive excess-only policy.

In the name of "protect[ing] 'the interests of participants in employee benefit plans and their beneficiaries' " (31 F.3d at 375), the Sixth Circuit would deprive ERISA plan participants and beneficiaries of the right to elect the reduced-premium policy — *even though their ERISA health plan covers automobile accident-related expenses*. Members of ERISA plans like Respondent's plan in this case will now be forced to spend substantially more for full-coverage, *non*-coordinated insurance policies despite having comprehensive health coverage that extends to automobile accidents.

There is no dispute that Respondent's beneficiary, Stephan Roesch, enjoyed comprehensive health coverage under the plan and that, furthermore, this coverage extended to any medical expense incurred, whether automobile accident-related or not. The Court should contrast these facts with those in *Liberty Mutual Ins. Group v. Iron Workers Health Fund*, 879 F.2d 1384 (6th Cir. 1989). In that case the insured's health and accident coverage, provided through an ERISA-qualified benefits plan, did *not* cover motor vehicle accidents. The plan contained a clear exclusion, unqualified by any availability of other insurance. Individuals with such limited ERISA plan coverage are compelled to purchase more expensive, full-coverage automobile policies because they have no other applicable coverage with which to coordinate. The situation is fundamentally different, however, where, as here, the individual's ERISA benefits plan *does* cover (does not exclude) motor vehicle accident-related expenses.

To be sure, the plans of this type contain coordination of benefits clauses, with the intent that duplication of payment will be avoided and that the plan members will in no event go

uncovered (see plan COB clause, App., *infra*, 19a). Nevertheless, the distinction between *no* coverage (*Liberty Mutual*) and *coverage* (this case) remains, and is fundamental. The holdings reached by the lower courts in this case, the Michigan Supreme Court in *Frederick & Herrud, Inc.*, and the Sixth Circuit in *Auto-Owners*, would erase this distinction, and unnecessarily restrict ERISA plan members' freedom of contract.

CONCLUSION

This matter is of paramount importance not only to ERISA plan members and automobile insurers, but to all types of private insurers whose insureds might also be entitled to benefits under an ERISA plan with coordinated coverage. The petition for a writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX A — ORDER OF THE MICHIGAN SUPREME COURT DATED OCTOBER 28, 1994

Order
Entered: October 28, 1994

Michigan Supreme Court
Lansing, Michigan

Michael F. Cavanagh
Chief Justice

Charles L. Levin
James H. Brickley
Patricia J. Boyle
Dorothy Comstock Riley
Robert P. Griffin
Conrad L. Mallett, Jr.
Associate Justices

SC: 99062
COA: 146004
LC: 90-395445-CZ

99062(45)

ALLSTATE INSURANCE COMPANY,

Plaintiff-Appellant,

v

LUFTHANSA GERMAN AIRLINES,

Defendant-Appellee,

and

STEPHAN ROESCH,

Defendant.

Appendix A

On order of the Court, the motion for reconsideration of this Court's order of August 29, 1994, is considered, and it is DENIED, because it does not appear that the order was entered erroneously.

I, CORBIN R. DAVIS, Clerk of the Michigan Supreme Court, certify that the foregoing is a true and complete copy of the order entered at the direction of the Court.

October 28, 1994 s/ Corbin R. Davis
Clerk

31025

[stamped]
SEAL OF THE MICHIGAN
SUPREME COURT – LANSING

APPENDIX B — ORDER OF THE MICHIGAN SUPREME COURT DATED AUGUST 29, 1994

Order
Entered: August 29, 1994

Michigan Supreme Court
Lansing, Michigan

Michael F. Cavanagh
Chief Justice

Charles L. Levin
James H. Brickley
Patricia J. Boyle
Dorothy Comstock Riley
Robert P. Griffin
Conrad L. Mallett, Jr.
Associate Justices

SC: 99062
COA: 146004
LC: 90-395445-CZ

99062

ALLSTATE INSURANCE COMPANY,

Plaintiff-Appellant,

v

LUFTHANSA GERMAN AIRLINES,

Defendant-Appellee,

and

STEPHAN ROESCH,

Defendant.

Appendix B

On order of the Court, the application for leave to appeal is considered, and it is DENIED, because we are not persuaded that the question presented should be reviewed by this Court.

I, CORBIN R. DAVIS, Clerk of the Michigan Supreme Court, certify that the foregoing is a true and complete copy of the order entered at the direction of the Court.

August 29, 1994

s/ Corbin R. Davis
Clerk

80823

[stamped]
SEAL OF THE MICHIGAN
SUPREME COURT – LANSING

APPENDIX C — ORDER OF THE COURT OF APPEALS, STATE OF MICHIGAN DATED FEBRUARY 15, 1994

Court of Appeals, State of Michigan

ORDER

ALLSTATE INS CO V LUFTHANSA GERMAN AIRLINES

Docket # 146004

L.C. # 90-395445 CZ

Thomas J. Brennan
Presiding Judge

Maureen P. Reilly
Robert J. Danhof
Judges

The Court orders that the motion for rehearing is DENIED.

A true copy entered and certified by Ella Williams, Chief Clerk on

2-15-94
Date

s/ Ella Williams
Chief Clerk

[stamped]
STATE OF MICHIGAN
COURT OF APPEALS

APPENDIX D — OPINION OF THE COURT OF APPEALS, STATE OF MICHIGAN DATED DECEMBER 27, 1993

STATE OF MICHIGAN

COURT OF APPEALS

December 27, 1993

No. 146004
LC No. 90-395445-CZ

ALLSTATE INSURANCE COMPANY,

Plaintiff-Appellant,

v

LUFTHANSA GERMAN AIRLINES,

Defendant-Appellee,

and

STEPHAN ROESCH,

Defendant.

Before: Brennan, P.J., and Reilly and Danhof,* JJ.

PER CURIAM.

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* Retired Court of Appeals judge, sitting on the Court of Appeals by assignment.

Appendix D

Plaintiff appeals as of right a circuit court order granting summary disposition pursuant to MCL 2.116(C)(8) and (10) in favor of defendant on plaintiff's complaint for declaratory relief. We affirm.

Stephan Roesch, voluntarily dismissed from this suit, was injured in an automobile accident and incurred $67,000 in medical expenses, which plaintiff Allstate, Roesch's no-fault insurer, paid in full. Roesch was also eligible to receive benefits under defendant Lufthansa's employee medical-benefit plan, established pursuant to the Employee Retirement Insurance Security Act (ERISA), 29 U.S.C. § 1001 *et seq.* Both plaintiff's policy and defendant's benefit plan contained a coordination-of-benefits (COB) provision, purporting to assume only excess or secondary liability for expenses resulting from an automobile accident. According to the parties' later stipulation of facts, the COB provisions thus conflicted with each other.

Acting on its own COB provision, plaintiff sought recoupment from defendant, and declaratory relief in court. Plaintiff's theory was that since defendant was insured by an excess risk policy issued by Lloyd's of London, defendant's plan was an insured plan, and plaintiffs COB provision was entitled to primacy under *Federal Kemper Ins Co v Health Ins Administration, Inc,* 424 Mich 537; 383 NW2d 590 (1986) (interpreting MCL 500.3109a; 24.13109(1)). In response, defendant moved for summary disposition, arguing that since the excess-risk policy insured defendant itself but not its medical benefit plan, and did not govern the plan's benefits in any way, defendant's plan was self-funded within the meaning of the ERISA, which preempted MCL 500.3109a; 24.13109(1), and thus entitled the plan's COB provision to primacy under *FMC Corporation v. Holliday,* 498 US __, 112 L Ed 2d 356; 111 S Ct 403 (1990). The circuit court agreed with defendant.

Appendix D

On appeal, plaintiff first argues that the trial court erred in finding defendant's coverage secondary to plaintiff's coordinated no-fault coverage because Luftansa's purchase of "stop-loss" coverage rendered its medical benefit plan an insured plan which was not protected by the ERISA's "savings clause" from the effect of MCL 500.3109a; 24.13109(1). Plaintiff secondly argues that even if the ERISA insulates defendant's plan from the application of state insurance law, plaintiff is nonetheless entitled to full or partial reimbursement by virtue of either the plan's own language or the application of federal common law.

When reviewing a grant of summary disposition, we review the record to determine de novo whether the moving party was entitled to judgment as a matter of law. *Adkins v. Thomas Solvent Co,* 440 Mich 293, 302; 487 NW2d 715 (1992). We conclude that the trial court properly granted defendant's motion.

Plaintiff's first argument relies on holdings in *Northern Group Services, Inc v. Auto Owners Ins Co,* 833 F2d 85, 91 (CA 6, 1987) (an employer's purchase of stop-loss insurance renders its benefit plan an insured plan), and *Frankenmuth Mutual Ins Co v. Meijer, Inc,* 176 Mich App 675, 678; 440 NW2d 7 (1989) (following *Northern Group Services, supra*). However, to whatever extent the *Northern Group Services* holding survived the generally contrary holding of *FMC Corp, supra,* it has not survived subsequent cases. In *Lincoln Mutual Casualty Co v. Lectron Products, Inc, Employee Health Benefit Plan,* 970 F2d 206 (CA 6, 1992), the Sixth Circuit held that an employer's purchase of stop-loss insurance did not affect the preempted status of its benefit plan under the ERISA because to hold otherwise would be to permit the states to directly regulate a benefit plan, in contravention of the ERISA. *Id.* at 210. The

Michigan Supreme Court followed that holding in *ACIA v Frederick & Herrud, Inc,* 443 Mich 358, 361, 386, 389-390; __ NW2d __ (1993), affirming this Court's 1991 decision in the same case, 191 Mich App 471; 479 NW2d 18 (1991), and overruling *Federal Kemper* to the extent of any conflict. 443 Mich at 390. It is thus now settled law that the "purchase of stop loss insurance coverage does not transform a benefit plan into an insured plan for purposes of the ERISA." 191 Mich App at 475.

The first prong of plaintiff's second issue appeals to terms in defendant's COB provision suggesting its deference to state law notwithstanding ERISA preemption. Plaintiff thus argues in effect that a closer look at the terms reveals that the provision does not actually purport to assume only secondary liability for expenses resulting from an automobile accident. We decline to address this argument. Having stipulated to conflicting COB clauses, plaintiff may not now argue that the trial court erred in failing to examine terms which arguably lend themselves to a less conflicting interpretation. *Bloesma v. ACIA (After Remand),* 190 Mich App 686, 691, 692; 476 NW2d 487 (1991).

Finally, although the trial court did not address the federal common-law question, plaintiff preserved it by raising it in its responsive brief to defendant's motion. The Supreme Court resolved that question as well in *Frederick & Herrud, supra,* holding that the COB clause in an ERISA plan must be given its plain meaning despite the existence of a similar clause in a no-fault insurance policy as a matter of federal common law. 443 Mich at 361, 389. In so deciding, the Court did not adopt the pro-rata apportionment espoused in *Winstead v. Indiana Ins Co,* 855 F2d 430 (CA 7, 1988) and applied in *Auto Owners Ins Co v. Thorn Apple Valley,* 818 F Supp 1078 (WD Mich, 1993). Rather, guided by the federal district court's decision on remand in *Lincoln*

Appendix D

Mutual v. Lectron, 823 F Supp 1385 (ED Mich 1993), the Court held that where an ERISA plan provides that no-fault insurance is primary where the potential for duplication of benefits occurs, the plan's terms control, and the no-fault insurer is primarily liable for the benefits at issue. *Id.* at 387.

Defendant was entitled to judgment as a matter of law.

Affirmed.

/s/ Thomas J. Brennan
/s/ Maureen P. Reilly
/s/ Robert J. Danhof

APPENDIX E — OPINION AND ORDER OF THE CIRCUIT COURT FOR THE COUNTY OF OAKLAND, STATE OF MICHIGAN DATED OCTOBER 9, 1991

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE
COUNTY OF OAKLAND

Case No. 90-395445-CZ

ALLSTATE INSURANCE COMPANY, an Illinois insurance corporation,

Plaintiff,

v

LUFTHANSA GERMAN AIRLINES and STEPHAN ROESCH,

Defendants.

OPINION AND ORDER

This matter is before the Court on Defendant Lufthansa German Airlines' motion for summary disposition pursuant to MCR 2.116(C)(8) and (10).

The record reflects that Defendant Stephan Roesch, the son of a Lufthansa employee, was involved in an automobile accident in August, 1989. Plaintiff Allstate Insurance Company is Mr. Roesch's no-fault insurer and issued a no-fault policy which contained a coordinated benefits provision pursuant to MCLA 500.3109(a).

Defendant Lufthansa has established an employee benefit plan

pursuant to ERISA, 29 USCA 1001, *et seq,* which also contained a coordinated benefits provision under which the ERISA plan would be considered secondary to available no-fault coverage.

Both the provisions of the no-fault insurance policy and the ERISA plan purport to assume only excess or secondary liability for expenses incurred as a result of an auto accident and, therefore, the policy and plan conflict with one another.

Lufthansa is protected by an excess risk insurance policy issued by Lloyd's of London which reinsured Lufthansa for excess loss or individual claims exceeding $125,000 up to a limit of $1 million. The excess risk policy does not provide payments to individual beneficiaries or health care providers. Lloyd's is not a plan administrator and plays no role in administration of the plan or the determination of benefits.

The coordinated benefits and exclusionary clauses relied on by Defendant are contained in the Lufthansa plan, not the excess risk loss insurance with Lloyd's. The coordinated benefits provision relied on by Plaintiff Allstate is contained within the coordinated no-fault policy.

At present, Defendant Roesch has incurred approximately $66,000 in medical and other expenses which have been paid by Allstate. This action is Allstate's action for recoupment, under its coordinated benefits provision, of amounts paid to Defendant Roesch that might be payable under the Lufthansa plan but for its coordinated benefits provision.

The issue before the Court is whether Lufthansa's plan is a self-funded employee benefit plan within the meaning of ERISA, and whether ERISA preempts the state insurance laws on which Plaintiff

relies. The Court has reviewed the arguments of both parties and the evidence presented, as well as the U.S. Supreme Court case, *FMC Corp v. Holliday,* 498 US __; 112 L Ed 2d 356; 111 S Ct 408 (1990), on which Defendant Lufthansa relies.

In *FMC,* the Court addressed the issue of whether ERISA's "deemer clause" protects self-funded ERISA plans from all state insurance regulations. The Court held that ERISA preempts state laws, even those that regulate insurance, as they relate to self funded plans. The Court noted that employee benefit plans that are insured are subject only to indirect state insurance regulation because an insurance company that insures a plan remains an insurer for purposes of state laws "purporting to regulate insurance." Therefore, an ERISA plan is bound by state insurance regulations only insofar as such regulations apply to the plan's insurer.

In the present case, the Court's satisfied that Lufthansa's employee benefit plan is a self-funded plan within the meaning of ERISA. Plaintiff attempts to bring the Lufthansa plan within the ERISA savings clause by characterizing the plan as insured due to the existence of the Lloyd's excess risk policy. The Court notes, however, that this insurance policy insures only the plan and does not provide payments to individual beneficiaries or health care providers. The excess risk policy does not create a direct relationship between the insurer and the participants-employees. Applying the holding of *FMC,* the Court finds that Lufthansa's plan, as an ERISA plan, is relieved from direct regulation by any state laws which purport to regulate insurance.

Also pursuant to *FMC,* the Court notes that plans that are insured are subject to indirect state insurance regulation only to the extent that such regulation applies to the plans' insurers. In the present case, even if the Lloyd's policy rendered the plan "insured" for purposes of

Appendix E

ERISA's savings clause, Michigan insurance laws are not applicable to Lloyd's, since the excess risk policy is a contract for reinsurance, not for health and accident coverage, the risk is located outside Michigan and the insurance was procured outside Michigan. MCLA 500.402b.

In conclusion, the Court notes that the Supreme Court in *FMC* emphasized support for a broad reading of the deemer clause because a narrow reading would cause endless conflicts between state insurance laws and preemption under ERISA.

Therefore, the court finds that Lufthansa's plan is a self-funded plan and that ERISA preempts the Michigan insurance laws on which Plaintiff relies.

Defendant's Motion for summary disposition is GRANTED pursuant to MCR 2.116 (C)(8) and (10); Plaintiff's motion for summary disposition is DENIED.

IT IS SO ORDERED.

s/ Alice L. Gilbert
ALICE L. GILBERT, CIRCUIT JUDGE

DATED: OCT 09 1991

APPENDIX F — ALLSTATE INSURANCE POLICY – COORDINATION OF BENEFITS PROVISION

Coordination of Benefits

1. If medical expense benefits are identified as excess under Coverage VA in the declarations, Allstate shall not be liable to the extent that any elements of loss covered under Personal Protection Insurance allowable expenses benefits are paid, payable or required to be provided to or on behalf of the named insured or any relative under the provisions of any valid and collectible

   (a) individual, blanket or group accident disability or hospitalization insurance,

   (b) medical or surgical reimbursement plan,

   (c) workmen's compensation law, or similar disability law, or any state or federal government laws, or

   (d) automobile or premises insurance affording medical expense benefits.

2. If work loss benefits are identified as excess under Coverage VA in the declarations, Allstate shall not be liable to the extent that any elements of loss covered under Personal Protection Insurance work loss benefits are paid, payable or required to be provided to or on behalf of the named insured or any relative under the provisions of any valid and collectible

   (a) individual, blanket or group accident or disability insurance,

(b) salary or wage continuation program, including sick pay programs, or

(c) workmen's compensation law, or similar disability law, or any state or federal government laws.

APPENDIX G — LUFTHANSA GERMAN AIRLINES MEDICAL PLAN – COORDINATION OF BENEFITS PROVISIONS

GENERAL INFORMATION

Medical Expenses/Services Not Covered

In addition to those items previously described, there are certain other types of services and expenses the Plan does **NOT** cover. Among these are:

- Unnecessary treatment, unreasonable charges, or changes made prior to an individual becoming a Plan participant.

- Charges made for custodial care. This is care — services and supplies, room and board-furnished primarily to assist someone in the activities of daily living. Expenses for such care will not be covered regardless of the physician or provider by whom or by which they are prescribed, recommended or performed.

- Services not recommended and rendered by or under the direction of a legally qualified physician or surgeon.

- Medical expenses for occupational accident or illnesses.

- Health check-ups, except and to the extent described in the sections entitled "Annual Physical Examination" and "Well-Baby Care."

- Orthotic devices such as foot molds and arch supports.

- Convalescent or similar facility charges incurred in connection with mental or nervous disorders, including substance abuse and alcoholism.

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- Charges made by a person who normally resides in your home or is a member of your family.

- Treatment for which you or your Eligible Dependents would not have to pay if you were not covered by this Plan.

- Charges incurred by an individual while he or she is not an Eligible Dependent.

- Charges attributable to confinement in, or treatment received from a hospital owned or operated by the United States government, unless there is a legal obligation to pay such charges without regard to the otherwise existence of Plan benefits.

- Charges that are in any manner reimbursable through any public program, other than Medicare.

- Charges that are otherwise payable as described under "Coordination of Benefits."

- Eyeglasses, hearing aids or examinations for their prescription or fitting.

- Expenses for cosmetic surgery unless those expenses are incurred for reconstructive surgery –

  i) incidental or following surgery, as the result of an injury, infection or other disease of the involved body part, or

  ii) necessitated by congential disease or anomaly of a child which has resulted in a functional defect.

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- Charges for or in connection with dental treatment, unless

  a) such dental treatment is the result of an accidental injury to natural teeth or fixed or removable dental prosthodontics which also results in damage to surrounding tissue, or

  b) the expenses are incurred for hospital charges for room, board and necessary services and supplies

Coordination of Benefits

The Lufthansa German Airlines Medical Plan has been designed to assist you in meeting the costs of medical supplies and services. Since it is not intended that anyone receive greater benefits than actual charges incurred, benefits from this Plan will be coordinated with benefits payable from other plans so that no more than 100% of the allowable expenses incurred during a calendar year will be paid.

An allowable expense is any reasonable, customary and necessary item of expenses covered in full or in part under any one of the plans involved.

This provision applies to –

- all plans in which you or an eligible dependent are enrolled as a member of a group, and to

- automobile reparations (No-Fault or Uninsured Motorist) insurance which is required under any law of government, unless the law specifically prohibits coordination of benefits.

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Further, in the event that Medical Plan benefits are paid to a Plan participant for treatment of a condition resulting from an injury or illness and such participant receives payment (other than a coordination of benefit payment) with respect to such condition from any other source, including, but not limited to a judicial or arbitration award, judgment, or settlement, or any insurance settlement, the amount of the Medical Plan benefit payments paid with respect to such condition will be considered an overpayment and will be repayable to the Plan; provided, however, that the amount considered as an overpayment shall not exceed the amount of any such award, judgment or settlement.